



# Women's Fertility History

CONFIDENTIAL

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NAME (LAST, FIRST, MI)	DATE
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Age at which menses began \_\_\_\_\_

Are your periods painful? ' Yes ' No

How many days does the pain last? \_\_\_\_\_

How heavy is the bleeding? ' Light ' Medium ' Heavy

What color is the blood? ' Light red ' Red ' Dark red ' Purple  
' Brown ' Black

Is there clotting? ' Yes ' No

Do you have premenstrual tension? ' Yes ' No

Does your face break out before or during your period? ' Yes ' No

Do your breasts become tender premenstrually? ' Yes ' No

Do you bleed or spot between periods? ' Yes ' No

Are your menstrual cycles spaced irregularly? ' Yes ' No

How many days are there from one period to the next? \_\_\_\_\_

Date of last menstrual period \_\_\_\_\_

Number Year(s)

How many pregnancies have you had? \_\_\_\_\_

How many children have you had? \_\_\_\_\_

How many abortions have you had? \_\_\_\_\_

How many miscarriages have you had? \_\_\_\_\_

How many D&C's have you had? \_\_\_\_\_

Have you ever had an abnormal pap smear? ' Yes ' No

Have you ever had a cervical biopsy, operation, cauterization or conization? ' Yes ' No

Have you ever had a venereal disease? ' Yes ' No

Do you get yeast infections regularly? ' Yes ' No

Have you ever been diagnosed with a chlamydial infection? ' Yes ' No

Do you have chronic vaginal discharge? ' Yes ' No

Do you have any sores on your genitals? ' Yes ' No

Have you ever had Pelvic Inflammatory Disease? ' Yes ' No  
Were you treated for it? ' Yes ' No

How? \_\_\_\_\_

Date of last Pap smear \_\_\_\_\_

Have you ever been diagnosed with uterine fibroids? ' Yes ' No

Have you ever been diagnosed with endometriosis? ' Yes ' No

Have you ever been diagnosed with pelvic adhesions? ' Yes ' No

Have you ever been diagnosed with any pelvic abnormalities? ' Yes ' No

Have you taken any medications for gynecological conditions other than contraceptives?

Medication	Reason	How long?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have your cycles changed since they began? ' Yes ' No

How? \_\_\_\_\_

Do you ovulate on your own? ' Yes ' No

On what day of your cycle? \_\_\_\_\_

Do your breasts get tender at/during ovulation? ' Yes ' No

Do you get premenstrual low back pain? ' Yes ' No

Do your bowel movements become loose or soft at the beginning of your period? ' Yes ' No



## Women's Fertility History (continued)

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NAME (LAST, FIRST, MI)	DATE
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Have you had fertility treatments? ' Yes ' No

If yes, when and where? \_\_\_\_\_

By whom? \_\_\_\_\_

What type(s)? \_\_\_\_\_

Have you taken medication to help you ovulate? ' Yes ' No

What were the results? \_\_\_\_\_

Have you had any tubal operations? ' Yes ' No

Have you had any hormone laboratory tests performed? ' Yes ' No

What were the results? \_\_\_\_\_

Do you have a single partner with whom you have been trying to conceive? ' Yes ' No

If yes, has he had a sperm analysis? ' Yes ' No

What were the results? \_\_\_\_\_

Is your partner supportive of your desire to conceive? ' Yes ' No

Have you taken oral contraceptives? ' Yes ' No

When? \_\_\_\_\_ How long? \_\_\_\_\_

Have you ever had an IUD? ' Yes ' No

When? \_\_\_\_\_ How long? \_\_\_\_\_

Have you ever taken DepoProvera? ' Yes ' No

When? \_\_\_\_\_ How long? \_\_\_\_\_

How long have you been trying to conceive? \_\_\_\_\_

Have you had a diagnosis relating to infertility? ' Yes ' No

If yes, what was it? \_\_\_\_\_

How is your sexual energy? ' Low ' Normal ' High'

Do you douche regularly? ' Yes ' No

With what? \_\_\_\_\_

Do you use vaginal lubricants? ' Yes ' No

Are you more than 20% over your ideal body weight? ' Yes ' No

Are you more than 20% under your ideal body weight? ' Yes ' No

Do you have a stressful occupation? ' Yes ' No

Do you exercise regularly? ' Yes ' No

Do you have excessive facial hair? ' Yes ' No

Do you have excessively oily skin? ' Yes ' No

Have you experienced excessive loss of head hair? ' Yes ' No

Have you noticed discharge from your nipples? ' Yes ' No

Was your mother exposed to diethylstilbestrol (DES) when she was pregnant with you? ' Yes ' No

Have you been exposed to any known environmental toxins or hormones? ' Yes ' No

Are you currently taking steroids? ' Yes ' No